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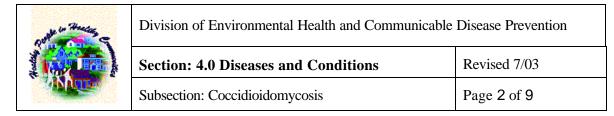
Section: 4.0 Diseases and Conditions Updated 7/03

Subsection: Coccidioidomycosis

Page 1 of 9

Coccidioidomycosis Table of Contents

Coccidioidomycosis
Fact Sheet
Disease Case Report (CD-1)
Record of Investigation of Communicable Disease (CD-2)



Coccidioidomycosis

(Valley fever, San Joaquin fever, Desert fever, and Desert rheumatism)

Overview^(1,2)

For a complete description of coccidioidomycosis, refer to the following texts:

- Control of Communicable Diseases Manual (CCDM).
- Red Book, Report of the Committee on Infectious Diseases.

Case Definition(3)

Clinical description

Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems.

Clinical case definition

An illness characterized by one or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

Laboratory criteria for diagnosis

- Cultural, histopathologic, or molecular evidence of presence of *Coccidioides immitis*, or
- Positive serologic test for coccidioidal antibodies in serum or cerebrospinal fluid by:
 - 1. Detection of coccidioidal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitin, or
 - 2. Detection of rising titer of coccidioidal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation, or
- Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms

Case classification

Confirmed: a case that meets the clinical case definition and is laboratory confirmed

Other water	Division of Environmental Health and Communicable Disease Prevention								
	Section: 4.0 Diseases and Conditions	Revised 7/03							
Nuite	Subsection: Coccidioidomycosis	Page 3 of 9							

Information Needed for Investigation

Verify the diagnosis. List laboratory results as noted above. **Establish the extent of illness**. This disease is not transmitted person to person.

Case/Contact Follow Up And Control Measures

• Obtain travel history for the past 30 days and record in the "Other Pertinent Epidemiological Data" on the CD-2 report form.

Control Measures

See the Coccidioidomycosis section of the <u>Control of Communicable Disease Manual</u> (CCDM), "Control of patient, contacts and the immediate environment".

See the Coccidioidomycosis section of the <u>Red Book</u>.

Laboratory Procedures

Specimens:

Contact the Regional Communicable Disease Coordinator. The Missouri State Public Health Laboratory does <u>not</u> culture for *Coccidioidomycosis*.

Reporting Requirements

Coccidioidomycosis is a Category II disease and shall be reported to the local health authority or to the Missouri Department of Health and Senior Services (DHSS) within three days of first knowledge or suspicion by telephone, facsimile or other rapid communication.

- 1. For confirmed and probable cases, complete a "Disease Case Report" (CD-1) and a "Record of Investigation of Communicable Disease" (CD-2).
- 2. Entry of the completed CD-1 into MOHSIS negates the need for the paper CD-1 to be forwarded to the Regional Health Office.
- 3. Send the completed secondary investigation form (CD-2) to the Regional Health Office.
- 4. All outbreaks or "suspected" outbreaks must be reported as soon as possible (by phone, fax or e-mail) to the Regional Communicable Disease Coordinator. This can be accomplished by completing the Missouri Outbreak Surveillance Report (CD-51).
- 5. Within 90 days of the conclusion of an outbreak, submit the final outbreak report to the Regional Communicable Disease Coordinator.

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	Section: 4.0 Diseases and Conditions	Revised 7/03						
A Phone	Subsection: Coccidioidomycosis	Page 4 of 9						

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- Chin, James, ed. "Coccidioidomycosis (Valley fever, San Joaquin fever, Desert fever, Desert rheumatism, Coccidioidal granuloma)." <u>Control of Communicable Diseases Manual</u>. 17th ed. Washington, DC: American Public Health Association, 2000: 117-119.
- American Academy of Pediatrics. "Coccidioidomycosis." In: Peter G, Ed. <u>1997 Red Book:</u> <u>Report of the Committee on Infectious Diseases</u>. 24th Ed. Elk Grove Village, IL. 1997: 181-183.
- 3. Centers for Disease Control and Prevention. <u>Case Definitions for Infectious Conditions Under Public Health Surveillance</u>. MMWR 1997:46 (No. RR-10): 10-11.
- 4. Stevens, David A. "Coccidioides Immitis." Principles and Practice of Infectious Diseases. 4th ed. Eds. Gerald L. Mandell, John E. Bennett, and Raphael Dolin. New York: Churchill Livingstone, 1995: 2289, 2365-2375.

Other Sources of Information

- 1. Bronnimann, D.A., et al. Coccidioidomycosis in the acquired immunodeficiency syndrome. Ann Int Med 106(3): 372-379, 1987.
- Centers for Disease Control and Prevention. <u>USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus</u>. MMWR 44:1-24, 1995.
- 3. Fish, D.G., et al. Coccidioidomycosis during human immunodeficiency virus infection. Medicine 69(6): 384-391, 1990.
- 4. Galgiani, J.N., et al. Fluconazole therapy for coccidioidal meningitis, Ann lnt Med 119(l): 28-35, 1993.
- 5. Galgiani, J.N., et al. Coccidioidomycosis in human immunodeficiency virus-infected patients. J Infect Dis 162(5): 1165-1169, 1990.
- 6. Hostetler, J.S., et al. Coccidioidal infections with amphotericin B collioidal dispersion (Amphocil or ABCD). 32nd ICAAC, abstract 628: 215, 1992.

Web Sites

- 1. The University of Arizona/Arizona Research Laboratories Valley Fever (Coccidioidomycosis) http://www.arl.arizona.edu/vfce/index.html (4 June 2003).
- 2. University of California at Irvine Coccidioidomycosis http://emedicine.com/EMERG/topic103.htm (4 June 2003).

Coccidioidomycosis

Valley fever, San Joaquin fever, Desert fever, and Desert rheumatism FACT SHEET

What is Coccidioidomycosis?

A disease caused by breathing in a fungus found in the soil in certain parts of the southwestern U.S., Mexico, and Central and South America.

What causes this disease?

Infection is caused by breathing in spores of a fungus found in desert regions.

What is the incubation period for this disease?

The incubation period is 10 to 30 days.

What are the symptoms?

Cough, chest pain (varies from mild sense of constriction to severe), fever, fatigue, headache, joint aches, and rash. Occasionally painful red bumps appear on lower legs. These bumps gradually turn brown.

How serious is this disease?

About 60% of infections cause no symptoms and are only recognized by a positive skin test. In the remaining 40%, symptoms range from mild to severe. Dark-skinned people and people with a weak immune system often have more serious infections. The acute form can develop into widespread disseminated disease or into a chronic pulmonary (lung) disease after a long latent period. Occasionally, the disease can spread throughout the body or develop into chronic lung disease after a period of no symptoms.

How can I avoid exposure to the fungus that causes this disease?

Avoiding travel to regions where this fungus is found will prevent risk of developing this disease. Serious illness from this infection is rare, so prevention is usually not a concern except for immunocompromised people. In the southwestern U.S., it is estimated that 100,000 new infections occur each year.

How does the physician test for this disease?

Sputum smear, sputum culture, blood tests, skin tests, or chest X-rays may aid the physician in the diagnosis.

What is the treatment for this disease?

The disease is almost always benign and goes away without treatment. Bed rest and treatment of symptoms until fever disappears may be recommended.

Missouri Department of Health and Senior Services Section for Communicable Disease Prevention Phone: (573) 751-6113 or (866) 628-9891

Page 1 of 1 7/03



REPORT TO LOCAL PUBLIC HEALTH AGENCY DATE RECEIVED BY LOCAL HEALTH AGENCY

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MISSOURI DEPARTMENT OF HEALTH DISEASE CASE REPORT

_ or 1/800-392-0272 TELEPHONE _

For Consultation or Information

All diseases listed below are to be reported promptly to the local public health agency or the Missouri Department of Health. The diseases printed in boldface below must be reported immediately by telephone or fax. Any enteric disease or hepatitis A in a foodhandler, health care worker, day care or correctional facility must be reported immediately by telephone. Other diseases/conditions should be reported within 3 days of first knowledge or suspicion.

Follow-up epidemiologic information may be requested by local or state public health officials.

(Legal authorization: RSMo 192,006 and 192,020; 19 CSR 20-20,020 and 19 CSR 20-080; local statutes and ordinances).

REPORTABLE DISEASES IN MISSOURI

Outbreaks: suspected outbreaks of reportable diseases, other acute or occupationally-related diseases or conditions

AIDS/HIV:

AIDS'

HIV seropositivity* (confirmed) T-Helper (CD4+) lymphocyte count* on any person with HIV infection

Animal bites Anthrax

Aseptic meningitis

Botulism Brucellosis Chancroid Diphtheria

Encephalitis, post infectious Encephalitis, primary

Environmental/Occupational Conditions

Acute chemical poisoning Carbon monoxide poisoning Heavy metal poisoning

(lead, mercury, arsenic, cadmium and other)

Hyperthermia Hypothermia Lead exposure Methemoglobinemia

Occupational lung diseases

SECTION D

SEXUALLY TRANSMITTED DISEASES:

Chancroid

Chlamydia trachomatis infections

Gonorrhea **Syphilis**

SECTION E

ENTERIC AND PARASITIC DISEASES AND HEPATITIS A:

Amebiasis

Campylobacter infections

Cholera

E.coli O157:H7

Giardiasis

Hepatitis A

Listeria monocytogenes Salmonella infections

Shigella infections

Trichinosis

Typhoid fever

Yersinia enterocolitica

SECTION G

TUBERCULOSIS.

TB disease

TB infection

Disease from mycobacteria other than tuberculosis

 * Use Forms CDC 50.42A AND MO 580-1641 for AIDS/HIV.

Pesticide poisoning

Respiratory diseaes triggered by environmental

contaminants

Haemophilus influenzae disease, invasive, including meningitis

Kawasaki disease Legionellosis Leptospirosis Lyme disease Malaria

Measles

Meningococcal disease, invasive, including meningitis

Nosocomial outbreaks

Pertussis Plaque **Poliomyelitis Psittacosis** Rabies

Reve syndrome

Rocky Mountain spotted fever

Rubella Tetanus

Toxic shock syndrome

Tularemia

SECTION F

HEPATITIS:

Hepatitis A

Hepatitis B

Hepatitis B surface antigen (HBsAg) positive, pregnant women only

Hepatitis non-A, non-B

MISSOURI DEPARTMENT OF HEALTH

RECORD OF INVESTIGATION OF COMMUNICABLE DISEASE*

				· · · · · · · · · · · · · · · · · · ·		FOR CO	DDING O	NLY
Patient's Name						County	City	
Address		City	State	Zip Code	-	Twnshp.	Dise	ase
Birth / Se:	x Race M [] F W 1	N 🔲 Other	County of Resid	dence		Hospital		Source
Parent's Name If No	t Adult		Phone			, , ,		
Hospitalized I	Iospital Name		 	Date of Onset		Physician	t 1	
Physician's Name						Phone Number		
Address					Date			
Previous Address (if	f significant)			1.00	Date M	oved	 	
Place Employed or S	School Attended			Occupation	1			·
Date Reported	How did you first l	earn of this ca	ase?			Date		
Disease			☐ Sus		inning estigatio	n,		
Chief Clinical Sympt	toms with Dates:		<u>,,</u>			······································		
								
		 						
								
Treatment (type, am-	ount, dates):					· · · · · · · · · · · · · · · · · · ·		
		DIACNOST	IC I ABOBATORY	TESTS ON PATIEN	ጥ			
Type of Specimen	Date Collected	DIAGNOST	Result	TESTS ON TATIEN		Name of Laborat	ory	
·					, ,			
Are there other asso	ociated cases?		_If yes, how many	, and how associated	1?			
Household Sanitatio	n: [] Good	Milk Supply						
	Fair Poor		у					
	[_] , ,,,		Continued on rev					

CD-2 (rev. 8-85)

^{*} Special forms should be used for investigations of Diphtheria (CD 2A), Encephalitis or Meningitis (CD 2B), Enteric Infections (CD 2C), and Foodborne Outbreaks (CD 2D).

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		CONTACTS	(Household and O	than)		
Name	Age	Relation	Similar	Laboratory	Date	D 1
and Address	Sex	to Patient	Illness? Onset Date	Specimen	Collected	Result
						
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tive and Follow-up Note	es:					
						
able Source				_		
Recovered Died	Date of Deat	h	Cause of D	eath		